DEPUTY SECRETARY OF DEFENSE
1010 DEFENSE PENTAGON
WASHINGTON, DC 20301-1010

FEB 6 2002

Honorable Bob Stump
Chairman, Committee on Armed Services
House of Representatives
Washington, DC 20515-6035

Dear Mr. Chairman:

This report is provided pursuant to Congressional direction in Section 757 of Public Law 106-398 that the Secretary of Defense report on the extent to which physicians are choosing not to participate in contracts for furnishing of health care services to TRICARE-eligible beneficiaries in rural states. The report is also to recommend any actions that the Secretary can take to encourage more providers in rural states to participate in the TRICARE program.

The General Accounting Office (GAO) this year addressed in a report, GAO-01-620, its findings on the reasons why physicians refuse to participate in TRICARE. The GAO specifically studied Alaska, one of the rural states identified in Section 757. The GAO found that even though TRICARE reimbursement rates increased, it did not lead to higher participation rates. However, it did find that Alaska posed unique challenges due to its small number of physicians and difficult geography. In addition, the high demand for health care and the small supply of physicians allowed physicians to be selective in accepting patients. The Department's own analysis of the number of physicians and the reasons for their refusal to participate in TRICARE is consistent with the GAO's findings.

In response to concerns about whether physician payment rates were reducing access, Congress has granted the Department authorities to address this issue. The National Defense Authorization Act for Fiscal Year 2001 allows DoD to increase the reimbursement for network providers in certain circumstances. The proposed rule to implement this new authority will be published in the Federal Register shortly. This regulation will enhance the ability of the Department to improve access to network providers for our beneficiaries residing in rural areas when reimbursement rates are the principal impediment to providers joining the TRICARE network.

We will continue to do our utmost to see that we support our eligible beneficiaries with the highest quality, accessible medical care available.

Sincerely,

Enclosure:
As stated

cc:
Honorable Ike Skelton
Ranking Democrat

REPORT TO CONGRESS ON

PHYSICIAN PARTICIPATION IN TRICARE

IN RURAL STATES

INTRODUCTION

recent years there have been concerns about potential problems that TRICARE beneficiaries may have in getting access to professional providers. These concerns have centered around two problems.

First there sufficient number of network providers in areas where TRICARE rime is offered? If not, what are the reasons that providers are unwilling to join the network? What could be done to increase the number of network physicians?

Second in areas where beneficiaries do not have access to network providers is there sufficient number of professional providers willing to TRICARE beneficiaries' not, what could be done to improve the situation

The Department' interest in these two issues stems from its interest in ensuring that TR CARE beneficiaries have access to high quality health To ensure high quality health care the Department believes that is valuable to have beneficiaries enrolled in managed networks The Department believes that having beneficiary enrolled in managed care network with primary care physician (often referred to as Primary Care Manager or PCM) wil increase continuity of care nd will contribute to the quality of care. Consequently the Department wants to have its beneficiaries enrolled in managed care networks where this rollment is feasible and when beneficiaries find esirable TRICARE beneficiaries decide to enroll in TRICARE Prime, the Department wants to ensure that they can get timely appointments with primary care physicians and that they get ny required specialty care in timely manner The Department also wants to ensure that enrolled beneficiaries do not have to trave long distan to see their primary care physicia for specialty referrals

Recognizing that not all TRICARE beneficiaries want to enroll in TRICARE Prime and that is not fe ible to establish managed care networks that meet the Department' access standards (distance and timeliness standards for full complement of primary care and pecialty providers) in some areas particularly rural areas, the Department has second goal

to ensure that its beneficiaries who do not join available managed care networks or who live in areas where managed care networks are not available have the ability to see physicians who will not charge them exorbitant amounts for their care. The Department has set limits on the amounts that physicians can bill beneficiaries: physicians are allowed to charge up to 115 percent of the TRICARE payment limit, which is commonly referred to as the CMAC, or CHAMPUS Maximum Allowable Charge. However, the Department is concerned that some physicians will not allow beneficiaries to make appointments because they believe that 115 percent of the CMAC amount is insufficient payment or because they are concerned about slow claims payments. In these cases, beneficiaries either must travel long distances to find a provider who will accept TRICARE patients or the patient must pay the physician's entire bill out of pocket. This is a particular concern in rural areas where beneficiaries do not have access to an MTF or where a managed care network is not available.

These concerns are particularly acute in rural areas. To address these concerns, Section 757 of the National Defense Authorization Act for Fiscal Year 2001 contained three relevant provisions. **First**, Congress extended new flexibility to the Secretary of Defense to increase TRICARE reimbursement rates in areas where access to health care services is severely impaired. This authority allows the Secretary of Defense to establish higher payment rates for specific services if DoD determines that access to health care services would be severely impaired. This Act gave the Secretary guidance on determining whether access was severely impaired. This included consideration of "the number of providers in a locality who provide the services, the number of such providers who are CHAMPUS participating providers, the number of covered beneficiaries under CHAMPUS in the locality, the availability of military providers in the location or a nearby location, and any other factors determined to be relevant by the Secretary." The Department has drafted a regulation to implement this authority, which would allow the Secretary to apply higher rates to all similar services in a locality or to define a new locality for application of the higher payment rates.

Second, the Congress required the U. S. General Accounting Office (GAO) to submit a report which analyzed the utility of increasing TRICARE reimbursement rates. The GAO submitted its report earlier this year and concluded that,

> "Changing the TRICARE reimbursement rate nationally to the 70th percentile of billed charges would be costly, inflationary, and largely unnecessary. . . Moreover, an across-the-board increase is unnecessary at this time because the vast majority of military beneficiaries are obtaining the care they need through military physicians and civilian physicians who accept TRICARE's reimbursement rates." [1]

However, the GAO report noted that access is impaired in some remote and rural areas. The GAO looked closely at Alaska where reimbursement rates had been increased sharply by the Department. The GAO found that increasing reimbursement rates in Alaska was not effective. Specifically, the GAO concludes that:

> "Although DoD's across-the-board rate increase in one locality has not improved access to care, pressure remains for further increases. However, DoD must be judicious about using such rate increases because they will be costly. Problems with access to care are infrequent and primarily related to specialty care, yet across-the-board increases would raise rates for all types of physicians. Rate increases, targeted to localities where access to care is severely impaired, may improve access to care, but other problems such as the scarcity of physicians and transportation difficulties are likely to remain. Responding to physician demands to pay based on billed charges–a practice DoD abandoned in 1992 when its health care costs were spiraling upward–would not only increase current program costs but also has the potential to further inflate government outlays, as physicians would likely raise rates over time, pushing TRICARE rates higher."

Third, the Secretary of Defense was required to submit a report to the Committees on Armed Services of the Senate and the House of Representatives on the extent to which physicians are choosing not to participate in contracts for the furnishing of health care in rural States. Specifically, Congress indicated that the report should include the following information:

a) the number of physicians in rural states who are withdrawing from participation, or otherwise refusing to participate, in the health care contracts;

b) the reasons for the withdrawals and refusals;

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[1] U.S. GAO, "Defense Health Care: Across-the-Board Physician Rate Increase Would be Costly and Unnecessary" (GAO-01-620, May 24, 2001.)

c) actions that the Secretary of Defense can take to encourage more physicians to participate in contracts;

d) recommendations for legislation that the Secretary considers necessary to encourage more physicians to participate in health care contracts.

For the purposes of this Section 757 report, a rural state was defined as having, according to the last decennial census: 1) fewer than 76 residents per square mile in the 1990 Census, and 2) fewer than 211 actively practicing physicians per 100,000 residents (not counting physicians employed by the U.S.) From examining 1990 Census population data and the most recently available physician volume data from the American Medical Association, we determined that the following 16 states currently meet this definition of rural.

TRICARE Region	Rural States designated under Section 757
Alaska	Alaska
Central (7/8)	Arizona, New Mexico, Nevada, Wyoming, Montana, South Dakota, Idaho, Utah, Kansas, Iowa
Heartland (5)	West Virginia
Southwest (6)	Texas, Oklahoma, Arkansas
Gulf South (4)	Mississippi

This report addresses the requirements of Section 757. Because one key factor which may lead physicians to not participate in TRICARE is the level of reimbursement, Section II of this report describes how physicians are reimbursed in TRICARE and how TMA monitors beneficiary access to professional providers. Section III then discusses what we know about the number of physicians who are withdrawing from TRICARE in rural states and the reasons for not participating. Finally, Section IV discusses suggested actions to encourage more participation in rural states.

II. TRICARE PROFESSIONAL PROVIDER REIMBURSEMENT AND ACCESS TO PROFESSIONAL SERVICES

Reimbursement

TRICARE's reimbursement of professional providers is based upon the methodology used by Medicare. The relationship of DoD payment levels to Medicare's for professional health care services is central to the ongoing success of TRICARE because payment levels have significant effects on DoD's ability to implement managed care programs, to assure beneficiary access to the full spectrum of health services, and to do these things cost-effectively.

It is appropriate that Medicare serve as the model for establishment of payment rates for TRICARE because Medicare is by far the largest payer for health services in the country, and as such its payment methodologies are carefully developed by the Executive Branch and the Congress, and subject to intense scrutiny by the public and by providers of health services. When payment rate policy was established by the Congress and the Executive Branch in the 1980s and early 1990s, CHAMPUS, being structurally similar to Medicare, and a considerably smaller program, neither attracted nor warranted the same degree of attention in development of reimbursement methods. Thus, Congress followed the prudent course of directing DoD to adopt or adapt Medicare payment approaches when appropriate.

Legislative initiatives to link DoD and Medicare payment rates for health care began in the early 1980s, with the initial focus on institutional services. DoD was directed to pay hospitals to the extent practicable using the same reimbursement rules as apply to Medicare providers. In 1986, a statutory provision was enacted requiring hospitals participating in Medicare to also participate in CHAMPUS. Similar initiatives have linked DoD's payment levels for professional services to Medicare. Based on General Accounting Office recommendations, Congress in 1988 directed that growth in CHAMPUS prevailing charges be limited through application of the Medicare Economic Index, which had been used since 1972 as a limit on growth in Medicare physician payments. Beginning in 1991, Congress directed that CHAMPUS payments be analyzed to identify overpriced procedures, and gradually to bring payment levels

for those procedures into line with payments under Medicare. TRICARE payment limits are called CMACs (CHAMPUS Maximum Allowable Charges).

In 1992, Medicare implemented the Medicare Fee Schedule, and began basing payment limits on the relative resource requirements of procedures, rather than on historical charges submitted by providers. In keeping with statutory direction, Medicare Fee Schedule amounts have become the target payment amounts for TRICARE. The National Defense Authorization Act for Fiscal Year 1996 codified the linkage to Medicare payment amounts.

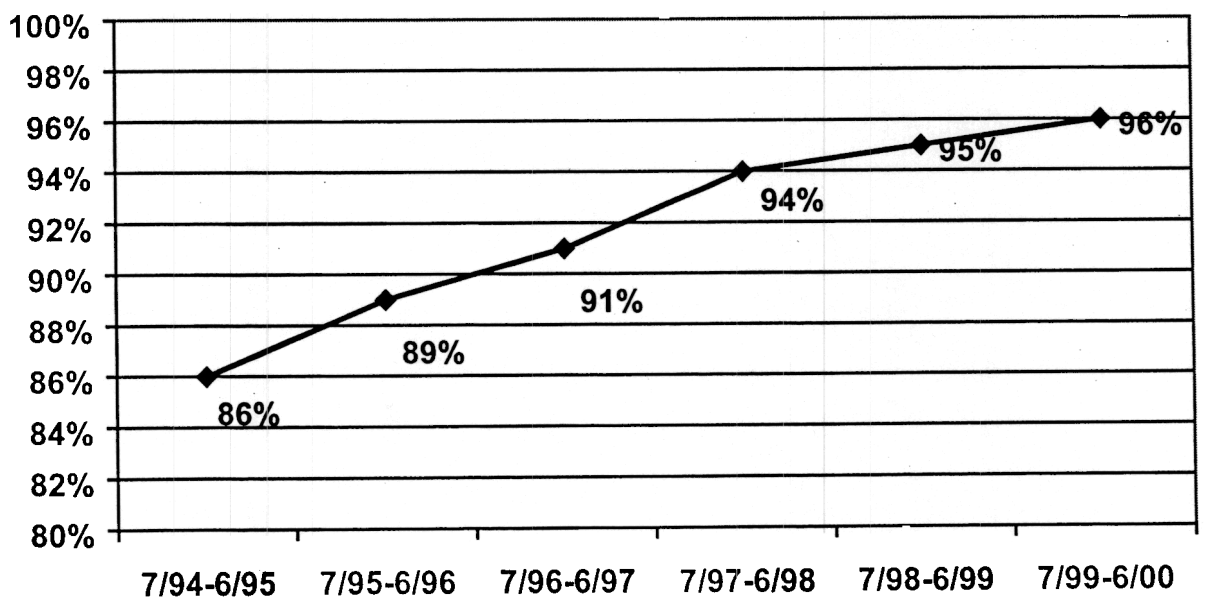
A key principle of DoD's activity in reimbursement design has been the protection of access to services. The statutory linkage of hospital participation in CHAMPUS to Medicare participation provided ample protection for DoD's beneficiaries, and enabled aggressive implementation of the CHAMPUS DRG-Based Payment System, which saved taxpayers (and beneficiaries) hundreds of millions of dollars per year. Lacking similar protections for physician services, DoD had to proceed more cautiously: payment levels have been gradually brought into harmony with Medicare's rates over several years, and special provisions are built into the process to stop reducing payments if access was threatened. Over 95 percent of physician CMAC rates are now at the same level as Medicare; fewer than 5 percent are higher than Medicare because their gradual transition to the Medicare level is not yet complete.

The amounts paid for health care services in TRICARE are governed by either the payment rules described above or on the basis of discounts from those rates. Each regional at-risk TRICARE contractor is required to establish a network of providers where the TRICARE Prime (HMO-type) option is offered, and the contractor attempts to negotiate reduced payment amounts with providers who join the network. Beneficiaries who enroll in TRICARE Prime use the network for most civilian health care services; beneficiaries who do not enroll retain their freedom to use any civilian provider under TRICARE Standard, but can take advantage of the discounted network under TRICARE Extra. DoD thus achieves efficiencies for itself and its beneficiaries while preserving freedom of choice of provider for those who do not wish to use the managed care options of TRICARE.

In a 1996 Report to Congress, DoD reviewed acceptance of its payment rates, and found that 86 percent of the time, physicians accepted the CMAC (or less) as payment in full; only 14 percent of services were subject to balance billing. More recently, this has increased to 96 percent acceptance, with only 4 percent of civilian services subject to balance billing (see Figure 1). For the small proportion of claims that are subject to balance billing, providers are prohibited from collecting more than 115 percent of the CMAC rate, just as in Medicare. However, as discussed below, this participation statistic does not address whether TRICARE beneficiaries can get appointments to see physicians.

Figure 1

TRICARE National Physician Participation Rates



Since 1998, TRICARE reimbursement rates have increased significantly. Because TMA has been transitioning from the prior CHAMPUS prevailing charges to the Medicare fee level for so many years now, most procedure code rates reached the Medicare level quite a few years ago. Thus, on average, physician CMAC rates are increasing now by about the same level that Medicare updates its fee schedule rates. Average CMAC rates for physician services increased

an aggregate 18 percent over the last three years (1998 levels to 2001 rates), or an average of almost six percent a year.[2] This is significantly higher than the general rate of inflation.

GAO's 1998 Review

In February 1998 the General Accounting Office issued a report, "Defense Health Care: Reimbursement Rates Appropriately Set; Other Problems Concern Physicians" (GAO/HEHS-98-80). In conducting the study from March 1997 to January 1998, the GAO reviewed the establishment of CMACs and contracted with actuaries to evaluate the methodology's compliance with statutory requirements; compared Medicare and CMAC rates; interviewed physicians and beneficiary advocacy groups in four locations; and interviewed TRICARE administrators and staff from TRICARE contractors.

The GAO study found that the CMAC methodology was sound, and that DoD saves about $770 million annually as a result of CMACs. The GAO also found that:

CMAC rates were generally consistent with Medicare's rates.

- Physician concerns focused on network discounts off CMACs, rather than on the acceptability of CMACs themselves. Local market factors were found to be the principal determinants of whether physicians would accept discounts off CMACs. Physicians also expressed concerns about administrative hassles and slow claims payments.

GAO suggested that DoD do a better job of informing physicians about payment rates, and informing beneficiaries about balance billing limitations. Payment rates are now available on the Internet, and the Explanation of Benefits for each claim describes the applicable balance billing limit. Revisions to claims payment timeliness requirements have addressed many concerns about slow payments. Physicians' concerns about timely claims payments have been addressed in other recent program improvements.

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[2] This excludes anesthesiologists and clinical laboratory services.

Monitoring Access

The Department of Defense is concerned about whether its beneficiaries have access to needed health care services. Access is a complex concept; it has a variety of meanings and can be measured in a variety of ways. MedPAC, the Congressionally-established organization that oversees the Medicare program, defines access as the "ability to obtain needed medical care." Given the subjectivity of the concept (i.e., how is "needed" defined? does ability mean financial ability and/or temporal ability?), it must be examined in different ways, ideally along several dimensions for a more complete picture, and methods may depend on the particular concern of the investigation. Access can mean availability of services, but it can also mean timeliness of service availability which is affected by geographic distance to providers and supply and distribution of providers.

With the introduction of the Medicare Physician Fee Schedule (which, as discussed above, is the basis for the CMACs), there has been considerable interest in the effect Medicare rates would have on access for Medicare beneficiaries. MedPAC has performed many different studies using a variety of methods to examine access issues. MedPAC has proposed a conceptual access model that can measure both process of care items (e.g., whether a beneficiary has a regular source of care, service utilization, etc.) and access outcomes (e.g. satisfaction, mortality, preventable conditions, etc.). Some of the main ways that MedPAC has studied access for the Medicare program have been: 1) beneficiary surveys (asking about satisfaction, usual source of care, whether care has been delayed due to cost or other reasons, etc.); 2) provider surveys (asking about acceptance of new patients, satisfaction with payment/program, willingness to provide services, complaints, etc.); 3) analysis of beneficiary complaints to Congressional offices and beneficiary service organizations; 4) comparisons of Medicare rates to other payers' rates; and 5) claims-based analyses. The claims-based analyses have consisted of measuring changes in service utilization (which is problematic as there can be many reasons for changes in service patterns and volumes) and physician participation/assignment rates.

TMA conducts a variety of surveys designed to gain insight into the satisfaction of its beneficiaries. The Health Care Survey of DoD Beneficiaries provides TMA with valuable feedback regarding satisfaction with health care, satisfaction with the health plan (TRICARE) and various access issues, such as "getting needed care". While a great amount of information is available via this survey, such as PCM type (military v. civilian) and enrollment status, it has limitations. Since its inception, the questions contained within the survey have not been consistent, which complicates the ability to analyze trends. As part of its annual evaluation of TRICARE, IDA and CNA have looked at access using the surveys discussed above. The CNA/IDA FY 2000 Report to Congress found that, "access to health care generally improved under TRICARE."[3] The CNA/IDA evaluations found that there were improvements in realized access, availability, and the process of obtaining care. Specifically, they found that a greater proportion of the TRICARE population was able to get care when they felt they needed it.

A second measure is the acceptance of payment rates by professional providers in an area. This is a method that has been used by the PPRC (the predecessor to MedPAC), among others. Specifically, this measure reflects the degree to which beneficiaries see providers who accept the TRICARE payment amount (CMAC) as payment in full. If beneficiaries are able to

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See Stoloff, Peter H., et. al., "Evaluation of the TRICARE Program: FY 2000 Report to Congress."

see physicians who accept the TRICARE payment as payment in full, one can infer that patients have not had difficulty in getting access to physicians. The physician participation rate is defined as the percentage of services for which the provider accepted assignment, or accepted the TRICARE allowed amount as payment in full. On the other hand, if the physician participation rate is low, one can infer that beneficiaries are having difficulty getting appointments with providers who do not "balance bill" them. Thus, although not a direct measure of access, we believe that physician participation rates should reflect access. In addition, looking at participation rates over time provides evidence about whether access is improving or deteriorating.

As measured by acceptability of payment rates, access to professional services in TRICARE is at its highest level in history. At the national level, 96 percent of the time providers accept the TRICARE payment amount as full payment, and do not balance bill the beneficiary.

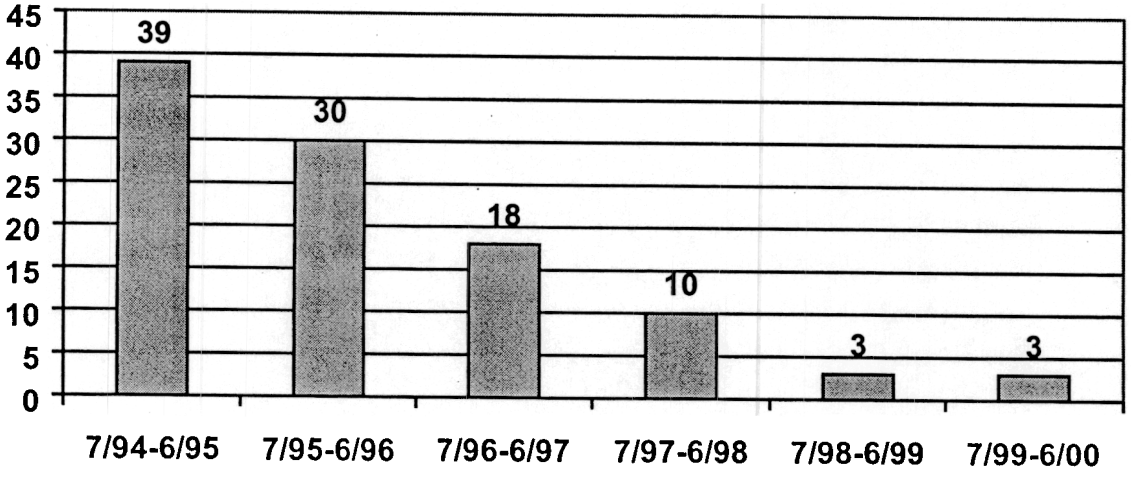
DoD is concerned that the very high average acceptance rate of TRICARE payments by professional providers may mask local access problems. When the CMAC payment system was implemented in 1992, national payment rates were adjusted to reflect local economic conditions in over two hundred "localities" by using the Medicare program's indexing technique for recognizing local variations. (This replaced the historical approach taken by CHAMPUS which based payments on statewide charge patterns.) Since then, the number of localities has been reduced to fewer than ninety due to the introduction of more statewide payment localities by Medicare, and hence for TRICARE, to replace smaller intrastate localities.

The number of states with low rates of provider participation has also dropped significantly in recent years. In the July 1994 – June 1995 period, the national TRICARE physician participation rate (for all physician services) was approximately 86 percent. At that time, 39 states had participation rates below that average level of 86 percent. As Figure 2 indicates, there are currently only three states in which participation rates are below 86 percent. We note that two of these states are rural states as defined by Section 757: Idaho (with a

participation rate of 84 percent) and South Dakota (with a participation rate of 80 percent.) Thus, the likelihood that a TRICARE beneficiary will be balance billed has declined dramatically.

Figure 2

Number of States With Physician Participation Rates of 85 Percent or Less



It is important to monitor not only the aggregate physician participation rate, but also the participation rates for specific types of care. As the GAO's recent report notes, "problems with access to care are infrequent and primarily related to specialty care..."[4] DoD has monitored closely participation rates by specialty and found that they have increased for all four major types of service (medical, surgical, radiology/pathology, and mental health) since the 1994-95 period (see Figure 3). In the 1994-95 period, none of these four types of services had participation rates above 88 percent on a national average basis. In contrast, by the 1999-2000 period, the national average physician participation rate for all four types of services had increased to 95 percent or more. Thus, for all major types of services, the likelihood of a TRICARE beneficiary being subject to balance billing is only about 1 in 20 on a national average basis.

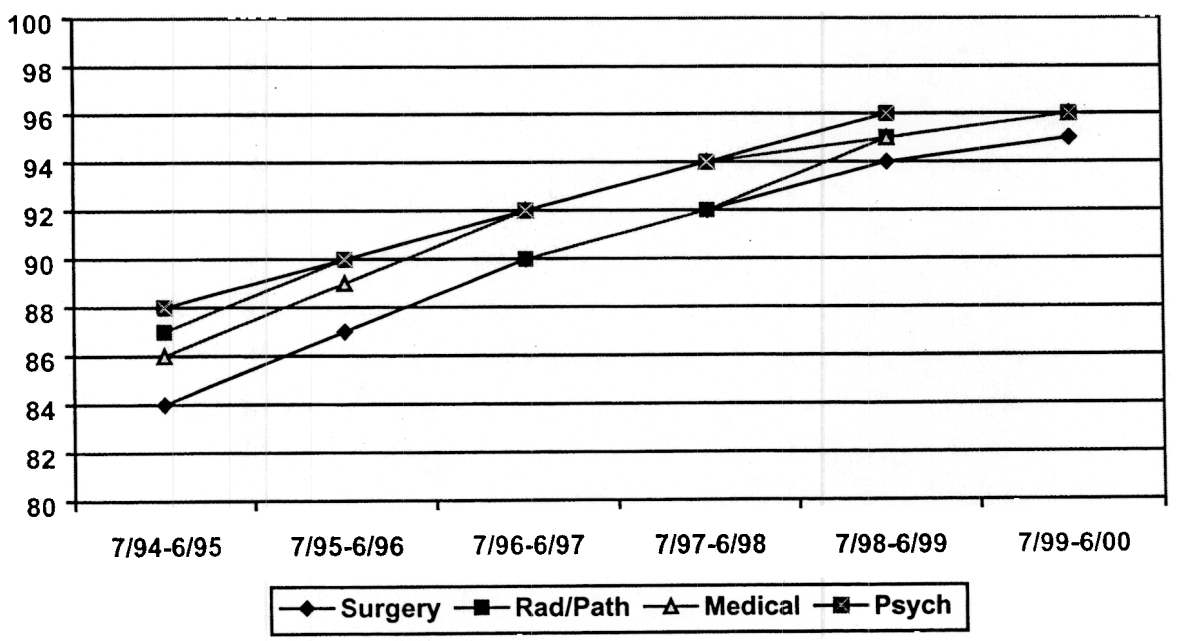
[4] U.S. GAO, "Defense Health Care: Across-the-Board Physician Rate Increase Would be Costly and Unnecessary" (GAO-01-620, May 24, 2001.)

Problems with specialty care can be pronounced in rural areas. Consequently, DoD has also monitored closely participation rates by type of service for different geographic areas. The number of states with low rates of participation for these four major types of care has also declined dramatically (see Figure 4.) In the 1994-95 period, more than one-half of all states had participation rates of 85 percent or less for each of the four major types of services. Five years later, only five states had a participation rate of 85 percent or less for any one of the four major types of physician services (see Figure 4.

One important reason for these increases in participation is the increased use of network providers by beneficiaries, which has been driven, in part, by the increase in Prime enrollment. Currently, over 80 percent of active duty dependents and over 25 percent of retirees under age 65 and their dependents are enrolled in Prime. As TRICARE Prime enrollment continues to increase, one would expect to see improvements in participation rates, but because these rates are so high already, future increases are likely to be modest.

Figure 3

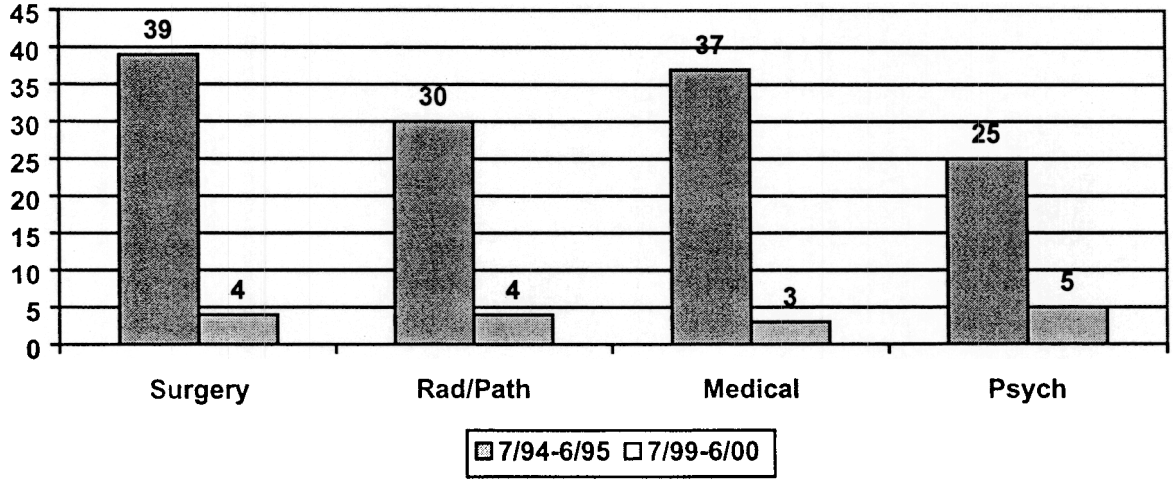
National Physician Participation Rates by Type of Service



Access problems persist in some locations. In late 1999, DoD undertook a redefinition of one statewide locality – for Alaska – in recognition of significant differences in acceptability of TRICARE payment rates in Anchorage compared to the rest of the state. Overall, CMACs are accepted as full payment almost 90 percent of the time in Alaska, but the vast majority of services are provided in Anchorage, so that severe access problems elsewhere are hidden. In an effort to increase acceptability of payment rates outside of Anchorage, DoD created a new locality, including all of Alaska except Anchorage, and, for the new locality, waived reductions in payment amounts taken since inception of the CMAC payment approach in 1992. The effects of this change are discussed in Section III of this report.

Figure 4

Trend in the Number of States With Physician Participation Rates of 85 Percent of Less, by Type of Service



Reimbursement for Network Providers

TRICARE Managed Care Support (MCS) contractors are responsible for providing an adequate network of qualified providers in areas which were designated under the terms of their contracts with the government. The network must include a complement of civilian professional providers adequate to ensure access to care for TRICARE Prime and Extra beneficiaries. In

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year for all TRICARE patients. Physicians who do not agree to "participate" are allowed to balance-bill the beneficiary for amounts over the CMAC that the provider would like to charge for a service, but by law, this amount is limited to only 15 percent over the CMAC level (similar to Medicare). This protects beneficiaries from excessive liabilities on claims from non-network, non-participating physicians.

III. PROVIDER PARTICIPATION IN TRICARE CONTRACTS AND ACCESS ISSUES IN RURAL STATES

Section 757 of the FY 2001 Defense Authorization Act required DoD to address whether physicians from rural states were either refusing to participate or withdrawing from the health care contracts. The Congress also indicated that they were interested in the reasons for withdrawals and refusals to participate. The Department attempted to answer these questions in a number of ways. First, the Department looked intensively at physician participation in the TRICARE contracts in Alaska. Second, the Department examined physician participation issues in the other 15 states designated as rural in Section 757.

Alaska Experience

TRICARE beneficiaries have had difficulty getting access to physicians in Alaska, particularly areas outside of Anchorage. Even though physician participation rates were high in Alaska, beneficiaries reported that they were unable to get appointments from some physicians and the Lead Agent was unable to get some physicians to join the TRICARE network. In an effort to increase acceptability of payment rates outside of Anchorage, DoD created a new locality, including all of Alaska except Anchorage, and, for the new locality, waived reductions in payment amounts taken since inception of the CMAC payment approach in 1992. This resulted in a 28 percent increase in reimbursement rates.

The results of this payment increase have been studied by both the Department and the GAO. Both the Department and the GAO found that ***fewer*** Alaska physicians accepted TRICARE patients after this reimbursement increase. In fact, the GAO analyzed DoD data and found that the number of physicians decreased more in rural Alaska (where the rates were increased) than in the Anchorage area where the rates did not increase.[5] This is shown in Table 1

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[5] U.S. GAO, "Defense Health Care: Across-the-Board Physician Rate Increase Would be Costly and Unnecessary" (GAO-01-620, May 24, 2001.)

Table 1

Change in Number of Civilian Physicians Treating TRICARE Patients: Before and After the Alaska Rate Increase

	Anchorage			Rest of Alaska		
	March to August 1999	March to August 2000	Percent change	March to August 1999	March to August 2000	Percent change
Number of civilian physici treating TRICARE patients	417	380	-9%	454	389	-14%

The GAO report identifies six reasons why the number of physicians may not have increased:

- First, the TRICARE rates may still be low compared to other payers in Alaska.
- Second, physicians may have been upset by the Coast Guard's reduction in reimbursement rates for active duty personnel in Alaska.
- Third, Alaska poses unique challenges due to its small number of physicians and difficult geography.
- Fourth, the high demand for health care and the small supply of physicians allows physicians to be selective in accepting patients.
- Fifth, some Alaska providers may not want to participate in a "government" program.
- Sixth, some physicians are unwilling to accept TRICARE patients because they regard these patients as transients; at the same time, they accept Medicare patients (at the same payment rates as TRICARE) because of "community obligations and long-standing relations" with these patients.

The Department's own analysis of the number of physicians and the reasons for their refusal to participate in the TRICARE contracts are generally consistent with the GAO's findings.

Experience in Other Rural States

The Department also attempted to examine the number of physicians who were willing to participate in the TRICARE contracts in the other rural states. First, the Department attempted to analyze the experience in Idaho, another rural state with reported access problems. The Department examined the provider identification numbers on the HCSR claims data and found that the provider IDs used on the HCSRs in Idaho are particularly difficult to itemize and analyze, as many different providers are listed under the same Employer Identification Number (EIN). Unfortunately, the 4-digit sub-provider ID was not unique enough to form a reliable count of individual providers (i.e., the same provider would be listed multiple times under different EINs and/or sub-IDs), and appeared to change on a fairly regular basis for the same provider (by contractor or even annually, otherwise). Therefore, the Department did not think an analysis of provider IDs was sufficiently reliable to indicate trends in actual counts of physicians providing services.

As an alternative, the Department reviewed the trends in each of the rural states with the relevant Lead Agents staff members and discussed the trends in the number of physicians willing to participate in TRICARE contracts as well as the reasons for withdrawals and for not participating. We first discuss network providers and then non-network providers.

Network Providers

In general, the number of network providers in these 16 rural states has been increasing in recent years. In fact, the net number of network providers has increased in almost all rural states. Overall, the fluctuations that have occurred have been the normal changes expected in any provider network. One exception is Alaska: as discussed above, there have been some declines in the Alaska network. The Lead Agent staff for Alaska indicated that 266 providers have left the network since 1997.

Although the number of network providers has been increasing in these rural states, almost all of these rural states have trouble recruiting or retaining many subspecialties in the networks. In most cases, there are simply not very many subspecialists practicing in these rural areas, particularly away from the larger cities. In almost all of these rural states, some specific specialties (dermatology, cardiology, neurology, gastroenterology, allergy, many types of surgery) are difficult to find for the networks. In contrast, the networks have generally been able to recruit pediatricians and general/family practice physicians. Mississippi was the only state where a shortage of primary care managers was cited in a few areas (Natchez and Tupelo), but most of those problems have been resolved

In some of the 16 rural states, the Lead Agent staff was unable to identify any notable reasons for termination or excessive network provider turnover rates; instead, terminations were for a variety of usual reasons (providers moving away, etc.) and the turnover rate was within normal expectations. In other states, some specific issues were identified. In West Virginia, low reimbursement rates were cited as the main barrier to provider recruitment for the network; however, the issue was the discounts that network providers were expected to give off the CMAC, rather than the level of the CMAC. The Lead Agent staff for the Southwestern states (AR, OK and TX) indicated that some physician specialists who perform ambulatory surgery (e.g., dermatology, ENT, orthopedics) were particularly disturbed about the TRICARE Claimcheck software which reviews submitted claims and denies payment for certain procedures which it considers "bundled" into other submitted procedure codes (i.e., not separately billable as already included in the payment for another code). These providers indicated that the TRICARE Claimcheck process denies payment for billed services that other payors do not, and this creates a lot of provider dissatisfaction. A third reason cited for network provider turnover was management or network administrative problems and hassles.

In summary, some access problems to network providers are perceived in almost all of the 16 rural states, but mainly for specialists in the more rural areas. Lead Agents reported that most network providers were seeing new patients in all these states, although the Lead Agent for Alaska indicated that new patient loads were often limited and that sometimes network providers would not see new patients due to low reimbursement rates.

Non-Network Providers

For the most part, the Lead Agents indicated no known changes in the availability of non-network providers to treat TRICARE beneficiaries under Standard CHAMPUS. Outside of Alaska, there are no reported access problems to non-network providers with the one exception of the Central region, where there is sometimes difficulty in finding obstetricians or specialists in the more remote locations. It is mainly difficult to find obstetricians in West Virginia and the Central Region states, and other subspecialists (e.g., orthopedics, dermatology, etc.) in the more rural areas. The general availability of physicians is confirmed by the high and increasing level of participation on claims (see Exhibit 1). We did find some nonparticipation in the more remote areas where there are fewer physicians practicing. In addition, we found that participation rates were increasing for almost all specialties except for mental health providers in these 16 rural states.

Several reasons were given for providers being unwilling to see TRICARE Standard patients. One is the complexity of TRICARE rules and uncertainty over benefits; another is the perception that TRICARE pays late (this was felt to be a carryover from past history rather than a real current problem, but the perception still remains in some areas). Because TRICARE patients are a very small portion of most providers' patient load, there is little incentive to participate on TRICARE claims. Other reasons cited for nonparticipation were low payment rates and dissatisfaction with the TRICARE Claimcheck bundling denials.

Exhibit

Trends in Physician Participation Rates in 16 Rural States, by Specialty

	Physician Participation Rates (July 1999 – June 2000)					Change in Rate From Previous Year				
State	Total Physicians	Surgical	Rad/ Path	Medical	Psych	Total Physicians	Surgical	Rad/ Path	Medical	Psych
AK	91%	85%	92%	91%	99%	0%	-1%	6%	-2%	2%
AR	95%	93%	93%	95%	97%	1%	0%	1%	-1%	-1%
AZ	98%	98%	98%	98%	96%	1%	1%	1%	1%	-2%
IA	92%	92%	92%	92%	94%	6%	3%	4%	8%	1%
ID	84%	78%	84%	84%	93%	1%	3%	3%	0%	-4%
KS	95%	95%	93%	95%	99%	0%	0%	0%	0%	0%
MS	96%	96%	98%	96%	97%	1%	2%	3%	0%	2%
MT	90%	87%	87%	91%	90%	5%	3%	4%	4%	1%
NM	97%	97%	96%	97%	96%	1%	1%	0%	1%	-2%
NV	98%	98%	99%	98%	99%	0%	0%	1%	0%	-1%
OK	96%	95%	95%	97%	96%	1%	1%	1%	0%	0%
SD	80%	79%	83%	80%	98%	5%	6%	2%	7%	0%
TX	97%	95%	96%	96%	97%	1%	1%	1%	0%	1%
UT	95%	95%	93%	95%	97%	4%	3%	5%	4%	0%
WV	96%	94%	95%	96%	97%	1%	1%	1%	1%	-2%
WY	94%	92%	95%	94%	98%	3%	3%	6%	2%	2%

Summary of Network and Non-Network Access Problems

There are pockets of small areas within all rural states that experience trouble in recruiting subspecialists to the networks, notably the areas outside the urban centers. While CMAC rates are perceived as a main reason for this in some of the 16 rural states, in other states the problem is seen as the requirement that network providers accept a discount off the CMAC. In many of these rural states, there is historical strong resistance to managed care for its oversight and administrative hassles. TRICARE has a history of claims payment problems, also, and that perception still remains to some extent, regardless of current experience. In fact, there is a shortage of many specialists in these rural areas, and there will always be access problems to specialists in these rural areas regardless of payment rates or insurance plan, because there simply are not very many in practice. There is no reason for some providers to join the TRICARE network as they have no shortage of patients.

Very few problems were reported with access to non-network providers, however. Only a few specialist shortages were mentioned, notably in Alaska and the Central region. Because there is no access problem, except in very rural areas, to physicians under Standard where they receive the same CMAC rate as in the network (if the contractor is not requiring discounts), it would appear that many physicians simply do not want to join the network rather than it being a reimbursement issue. In fact, balance billing (i.e., charging up to 15 percent more than CMAC, which providers are legally allowed to do when nonparticipating) was not noted as a common practice in these rural states under Standard claims submittal.

IV. SUGGESTED ACTIONS TO INCREASE PARTICIPATION IN RURAL STATES

There are undoubtedly several reasons there are more access issues in rural states. Some of the reasons cannot be changed, such as the low physician supply which leads to a less competitive environment in which physicians have historically been less likely to contract with managed care organizations (and have also been less likely to accept assignment.) The low physician participation rate has been observed in other programs, such as Medicare, so we do not believe that the lack of willingness to participate in TRICARE contracts can be attributed solely to TRICARE administrative or claims processing issues. In fact, the Medicare program's lowest statewide physician assignment rates are in Idaho, Wyoming, South Dakota and Nebraska. Local physicians' historical independence and attitudes will probably always play some role (we note that TRICARE has low average participation rates in Idaho and South Dakota, although the rates are above 90 percent in Nebraska and Wyoming).

There clearly is some dissatisfaction with CMAC rates by local physicians; this is evidenced by complaints from local professional associations and from discussions with local providers. Even though the TRICARE rates are not disproportionately lower in rural states than in non-rural states (in fact, they are probably higher in comparison to local cost-of-living in rural states than in major urban areas), the reality is that due to low physician supply and a noncompetitive environment, CMAC rates may be low for the marketplace.

There seems to be little evidence that low CMAC rates are really a major problem to network development in rural states. Most specialty shortages occur in very rural areas where specialists are in short supply and do not want to join managed care plans, in general. One issue is whether network physicians should be paid more than Standard physicians in some rural areas. That might increase network participation, but increase DoD costs unacceptably.

More and better provider education on the TRICARE plan should be undertaken in the next generation of contracts so that providers would understand the program better.

New Authorities

In response to potential concerns about whether professional payment rates were reducing access, DoD has been granted two new authorities. First, the FY 1996 Authorization Act allows DoD to establish higher payment rates for services than would otherwise be allowable. In order to implement this new authority, DoD published a Notice of Proposed Rule Making (NPRM) on May 30, 2000. As a result of the NPRM, a final rule was published on August 28, 2001. The rule would authorize the establishment of higher payment rates for services than would otherwise be allowable, if it is determined that access to health care services is severely impaired. Payment rates could be established in three broad ways:

through addition of a percentage factor to an otherwise applicable payment amount;

- by calculating a prevailing charge; or
- by using another governmental payment rate.

Higher payment rates could be applied to all similar services performed in a locality, or a new locality could be defined for application of the higher payment rates.

Second, the FY2000 Authorization Act allows DoD to increase the reimbursement for **network** providers. It would allow increases in provider payment rates if it is determined necessary to ensure adequate Preferred Provider networks. This authority would also be implemented as described in the May 30, 2000 NPRM. The NPRM indicates that the amount of reimbursement for a network health care service would be limited to the lesser of: (1) An amount equal to the local fee-for-service charge in the area where the service is provided; or (2) 115 percent of the otherwise allowable TRICARE rate for the service. The higher rate will be authorized only if all reasonable efforts have been exhausted in attempting to create an

adequate network and if DoD has determined that it is cost-effective and appropriate to pay the higher rate to ensure an appropriate mix of primary care and specialists in the network.

Finally, the Health Resources and Services Administration (HRSA) of the U. S. Department of Health and Human Services has the responsibility to designate what parts of the country are medically underserved. In the Medicare program, providers in these medically underserved areas, known as HPSAs (or Health Professional Shortage Areas), receive "bonus" payments from Medicare equal to 10 percent of their Medicare payments. TMA has recently published a regulation that will be implemented soon. As of implementation, TMA will also pay its providers in HPSA areas a 10 percent bonus. Because many counties in rural states are HPSA areas, this will allow many providers to receive bonus payments equal to 10 percent of their TRICARE payments. In effect, many rural providers will see TRICARE rates increase by 10 percent.

The Department believes that these two new authorities and the payment of HPSA bonuses will allow it to ensure that an adequate number of physicians will be willing to join the networks and see TRICARE patients.